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ABSTRACT

Under the Early Intervention Program for Infants and Toddlers with Disabilities (Part C) of the Individuals with Disabilities Education Act (IDEA), service coordination is defined as "the activities carried out by a service coordinator to assist and enable a child eligible under this part and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the State's early intervention program." This document describes the strengths and weaknesses of four different approaches to service coordination. These include: (1) dedicated service coordination, in which service coordination responsibilities are the primary focus of the role; (2) early interventionist and service coordination, in which a primary service provider also has service coordination responsibilities; (3) interagency service coordination, in which different agencies may provide service coordination; and (4) interim or intake service coordination, in which a service coordinator facilitates all activities during the first 45 days of service or until the Individualized Family Service Plan (IFSP) is implemented. There is no empirical basis for deciding which of these approaches is better. However, the following quality assurance indicators can be considered across all models: manageable caseloads, flexibility in caseloads, family choice, family participation, training, and system evaluation. (SG)

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Service Coordination Caseloads in State Early Intervention Systems

by
Joicey Hurth

Under the Early Intervention Program for Infants and Toddlers with Disabilities (Part C) of the Individuals with Disabilties Education Act (IDEA), service coordination is defined as :

> . . . the activities carried out by a service coordinator to assist and enable a child eligible under this part and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the State's early intervention program.
> (34 CFR Sec. 303.22(a)(1))

However, neither the federal IDEA statute nor regulations offer guidance on what constitutes a maximum, minimum, or typical caseload for a service coordinator.

In practice, service coordination models and caseloads vary greatly according to the model of service coordination used. The ongoing, supportive, family-centered service coordination described in Part C of IDEA *(see Table 1)* requires lower caseloads than do administrative models in which case managers are mainly determining eligibility and monitoring service provision.

This paper summarizes and provides examples of the models of service coordination in early intervention that the author has identified *(see Table 2)* . The information presented has been provided or reviewed by coordinators of the reporting states' Part C programs. The examples illustrate the variation in policies and practices and are neither inclusive nor exhaustive of all state approaches to service coordination. Implications for best practice are not intended. Indeed, each identified model of service coordination has inherent strengths and weaknesses. Each model's effectiveness depends upon its implementation, its fit with local needs and resources, and its integration with the larger early intervention system.

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Table 1
Sevice Coordination Under the IDEA Regulations for Part C

Sec. 303.22 Service coordination (case management).

(a) General. (1) As used in this part, except in Sec. 303.12(d)(11), service coordination means the activities carried out by a service coordinator to assist and enable a child eligible under this part and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the State's early intervention program.

(2) Each child eligible under this part and the child's family must be provided with one service coordinator who is responsible for—

(i) Coordinating all services across agency lines; and

(ii) Serving as the single point of contact in helping parents to obtain the services and assistance they need.

(3) Service coordination is an active, ongoing process that involves—

(i) Assisting parents of eligible children in gaining access to the early intervention services and other services identified in the individualized family service plan;

(ii) Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;

(iii) Facilitating the timely delivery of available services; and

(iv) Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.

(b) Specific service coordination activities. Service coordination activities include—

(1) Coordinating the performance of evaluations and assessments;

(2) Facilitating and participating in the development, review, and evaluation of individualized family service plans;

(3) Assisting families in identifying available service providers;

(4) Coordinating and monitoring the delivery of available services;

(5) Informing families of the availability of advocacy services;

(6) Coordinating with medical and health providers; and

(7) Facilitating the development of a transition plan to preschool services, if appropriate.

(c) Employment and assignment of service coordinators.

(1) Service coordinators may be employed or assigned in any way that is permitted under State law, so long as it is consistent with the requirements of this part.

(2) A State's policies and procedures for implementing the statewide system of early intervention services must be designed and implemented to ensure that service coordinators are able to effectively carry out on an interagency basis the functions and services listed under paragraphs (a) and (b) of this section.

(d) Qualifications of service coordinators. Service coordinators must be persons who, consistent with Sec. 303.344(g), have demonstrated knowledge and understanding about—

(1) Infants and toddlers who are eligible under this part;

(2) Part H of the Act and the regulations in this part; and

(3) The nature and scope of services available under the State's early intervention program, the system of payments for services in the State, and other pertinent information.

(Authority: 20 U.S.C. 1472(2))

Note 1: If States have existing service coordination systems, the States may use or adapt those systems, so long as they are consistent with the requirements of this part.

Note 2: The legislative history of the 1991 amendments to the Act indicates that the use of the term "service coordination" was not intended to affect the authority to seek reimbursement for services provided under Medicaid or any other legislation that makes reference to "case management" services. See H.R. Rep. No. 198, 102d Cong., 1st Sess. 12 (1991); S. Rep. No. 84, 102d Cong., 1st Sess. 20 (1991).

(34 CFR 303)

Dedicated Service Coordination

In this model, "service coordinator" is a personnel category, having only or primarily service coordination responsibilities. Service coordinators can be either employed by or affiliated with early intervention programs, or they can be *independent* of early intervention programs.

North Dakota has a history of providing case management under Developmental Disabilities (DD), the state's lead agency for Part C. Case management ratios are a maximum of 1:60, but in early intervention the average runs 1:40 or 1:45. The DD case manager coordinates family support services and monitors all service delivery. It is important to note that North Dakota families also receive ongoing support from their early intervention *home visitor*, whose caseloads are a maximum ratio of 1:15, with an average of 1:11 used for budgetary purposes.

More states are adopting a *dedicated* service coordinator model. *Indiana* recently developed a dedicated system under Part C, with recommended caseloads of 1:50. In any given month, a service coordinator can bill for 35 children (with a range of number of contacts, 2 to 4/month). The data system used in Indiana allows the state Part C program to monitor caseloads.

Hawai'i has a model with several personnel levels, ranging from supervisory to paraprofessional, and a wide range in caseloads of 1:3 to 1:95, with a median of 1:20.

South Carolina caseloads average 1:45 or 1:50 billable cases. *Misssissippi* has a ratio of 1:50, *Georgia* reports 1:32, and *Alabama* is maintaining a ratio of 1:20 or 1:30. *Tennessee* reports a caseload ratio of 1:40, and *Nebraska*'s ratio is 1:30.

Delaware has both dedicated service coordinators and coordinators who have additional evaluation responsibilities. The service coordinators are hired by the state's Part C lead agency, the Department of Health and Social Services, and, therefore, are *independent* of the early intervention programs, most of which are private providers. Caseloads range between 1:20 and 1:35. Service coordinators with evaluation responsibilities have the lower caseload ratios, and the range indicates flexibility to accommodate families' greater and lesser service coordination needs.

Early Interventionist and Service Coordination

In this model the primary provider of early intervention services also provides service coordination services. The *home visitor/case manager*, with roots in health and mental health services, has provided services to infant and toddlers with (or at risk for) developmental delays since the early 1960s.

Montana's Developmental Disabilities Program has used a home visitor model for early intervention and service coordination for many years. Based on prior experience, in 1988, Montana set 1:16 as a typical ratio for the early intervention, home visitor caseload. Providers negotiate a caseload contract every 2 years, in order to accommodate individual family needs and other variables, such as needing lower caseloads to reach rural remote families. Montana families with children who are medically fragile and families with other complex care needs are served by the state's Intensive Family Education and Support Program (IFESP). (Although there may be overlap in eligibility between the IFESP and the state's Part C program, families usually are served in one program or the other, not both.) The IFESP caseload ratio has been set at 1:8, reflecting the demands of coordinating services for families with intense needs.

Massachusetts and *Maine* both report a typical caseload ratio of 1:15 for their home visitors.

Probably the most common model in early intervention programs is the *multidisciplinary or transdisciplinary team model*, in which each team member has early intervention responsibilities as well as a caseload of families for whom they provide service coordination. Typically, the team member whose discipline most closely matches the child's primary service need is selected as the service coordinator for that family. *Texas* service providers are assigned cases at ratios ranging from 1:14 to 1:18; in *West Virginia* the caseload ratio ranges from 1:15 to a maximum of 1:18.

Project Continuity, an early childhood demonstration and outreach project at the University of Nebraska Medical Center in Omaha, and Child Development Resources (CDR), in Norge, Virginia, have studied the amount of time devoted to service coordination in early intervention and estimate caseload demands in employee full-time equivalents (FTEs). They both cite five to six families as representing a typical load for .20 to .25 FTE, although this does vary with family needs. These projects also reported similar data for the average time spent in service coordination activities for a family

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each month (Jackson et al., n.d.; C. Alport, personal communication, September 30, 1998). The range is great — from 30 minutes to 9 hours, with an average of approximately 6 hours — both among families and for any one family over time. Cathy Allport, from CDR, reported that family factors related to higher service coordination usage are income-related needs, medical involvement of the child, protective service involvement, and parents with disabilities.

Interagency Service Coordination

Because Part C-eligible families also may be served by other agencies that have service coordination or case management responsibilities, several states have adopted an interagency approach to selecting the person to be designated on the Individualized Family Service Plan (IFSP) as the coordinator of Part C services for a family. Typically, state and/or local interagency agreements assure that eligible infants and toddlers and their families receive service coordination that is in compliance with Part C, regardless of which agency's service coordinator is designated on the IFSP. Involving multiple agencies in service coordination provides for local flexibility and, usually, family choice, but it does present challenges for training and quality assurance.

North Carolina has a state-level interagency agreement for service coordination that involves multiple agency personnel at the local level. Early intervention providers serve as service coordinators for the majority of Part C-eligible children, with a typical caseload ratio of 1:18. It is interesting that early intervention support to children in child care has a lower ratio, 1:10 or 1:12, to allow for more intensive involvement. The Child Service Coordination Program provides dedicated service coordination (with caseloads of 25) for some Part C-eligible children who are also in the state's Smart Start Program. In addition, Department of Health case managers, who typically carry 50 children and families, may serve as the Part C service coordinator for any of their caseload who are Part C eligible.

In *Vermont*, service coordination is community based and any of the various agencies that serve Part C-eligible families may provide service coordination. Community resource parents (the point of entry to the early intervention system) serve the majority of families, and early intervention providers from various regional agencies and school personnel also frequently serve this role. Caseloads and family preference are considered when deciding whether the child and family will remain with an interim coordinator, or will

Table 2
Features of Four Service Coodination Models

Dedicated Service Coordination

- Service coordination responsibilities are primary focus of the role
- Service coordinators may be employed by an early intervention program
- Service coordinators may be independent of early intervention program, i.e., be employed by another agency, program, or project, or by a private provider

Early Interventionist and Service Coordination

- Primary service provider also has service coordination responsibilities
- Home visitor provides both intervention services and service coordination to a given caseload of families
- Trans- or multidisciplinary team — all team members have direct interventionresponsibilities and a selected caseload of families for whom they provide service coordination

Interagency Service Coordination

- Several different agencies may provide service coordination or case management services to Part C-eligible families
- The person to serve as the Part C service coordinator can be selected from the agency most appropriate to the family's needs and wishes
- State and/or local interagency agreements or activities, such as training, assure that service coordination meets Part C requirements.

Interim or Intake Service Coordination

- Single point of entry to early intervention system
- Interim service coordinator, usually dedicated, provides intake services and facilitates all activities during the first 45 days or until the IFSP meeting.
- At the IFSP meeting, interim service coordinators may be appointed as the ongoing service coordinator and continue in this capacity with some families

be assigned to another early interventionist or agency provider. A caseload ratio of 1:20 is typical.

Interim or Intake Service Coordination

Several states have an *interim service coordination model*, in which a single point of entry provides intake services, organizes evaluations, and serves as the service coordinator until the IFSP meeting. Essentially, the interim or intake coordinator facilitates the first 45 days of the family's entry to the early intervention system. Responsibilities may include explaining the early intervention system and Part C procedural safeguards, gathering information from families, coordinating evaluations, arranging financing for services, and connecting to services and supports such as parent networks. Some interim service coordinators may accompany the family to the first IFSP meeting, while others may only arrange to have the appropriate participants present. At the first IFSP meeting, the permanent service coordinator is selected.

Assignment of this permanent or ongoing service coordinator may follow any of the various models or combination of models described above. In *Vermont*, community resource parents and regional interventionists do the intake and may continue with a family or turn them over to an ongoing service coordinator from any one of a number of agencies (see interagency approaches above). Because Medicaid funds much of *Georgia*'s system, its "freedom of choice" requirement is satisfied by allowing families that are Medicaid eligible to choose from a list of all Medicaid-qualified and -enrolled providers of service coordination to select their ongoing service coordinator. Families that are not Medicaid eligible may choose from a list of state-funded and qualified service coordinators.

Caseloads for interim coordinators also vary, in part due to different intake responsibilities. For example, *Indiana* estimates that one interim service coordinator could manage up to 180 families annually. In a state with sliding fee scales or other significant administrative tasks, annual caseloads may be lower. For example, *Georgia* estimates each interim coordinator has responsibilities for 150-160 families annually.

Summary

Each approach to service coordination has inherent strengths and weaknesses. Each has proponents in the early intervention literature; however, there is not an adequate empirical basis for judging which is better or best. This paper does not intend to imply any quality judgments about the models or states listed or not listed above. Rather, it presents examples of various approaches that states have undertaken in developing statewide service coordination in early intervention. As states, service providers, families, and researchers accumulate and share experiences, some quality assurance indicators can be considered across models:

1. Caseloads must be low enough to allow a service coordinator to build a relationship with families and to understand their concerns, priorities, and resources. The service coordinator should be able to configure the IFSP process and to assist in the selection of providers and supports that meet the individual preferences and needs of each family.
2. Flexibility in caseloads is necessary to allow a range of support from intensive contacts to very few, depending on families' needs, desires, and location. Family needs for service coordination vary both among families and with any given family over time. Service coordination needs are likely to be greater at entry to the system, during transitions, (especially transitions at age 3 years), and at times of such acute or critical need as major changes in the health of a family member.
3. Family choice in selecting a service coordinator who can accommodate their needs and preferences is desirable. One family concerned mainly about their child's development may not want to deal with two people, preferring that the primary interventionist serve as the service coordinator. Another family, with health concerns or needing services from a variety of providers, may need a dedicated coordinator who knows the system and the community well. Interim service coordination models provide flexibility and choice. However, interim models can present other problems such as artificially dividing the IFSP process into disjointed steps involving many different people in evaluation, assessment, the IFSP meeting, and ongoing service and support.
4. Experienced family members are working in the service coordinator's role in various models. States

are recruiting parents as dedicated, independent, full-time or part-time service coordinators. Parents sometimes share responsibilities with another designated service coordinator, for example, assuming responsibility for making early contact with a family and serving as their guide through the early intervention process. Contracting on a consultant or fee-for-service basis with individuals allows some systems to better include representatives of different cultures and communities.

5. Training is essential. The greater the number of people, agencies, and programs involved in providing services to a family, the greater the flexibility and choice provided — but the training and administrative challenges also are greater. States must ensure that, no matter who acts as their service coordinator, a family experiences the type of family-centered services, rights, and safeguards that are in compliance with Part C of IDEA. As service coordinators work across agencies and in communities, supervision and other ongoing support strategies, such as mentoring, are extremely important. Adequate supervision is essential in those systems that employ paraprofessional-level coordinators, or recruit coordinators from diverse disciplines who may have widely varied experience, competence, and qualifications.

6. System evaluation, monitoring, and oversight are essential to maximize the system's strengths and correct for problems or inequities. Data is needed about the relationship of caseloads to family experience and outcomes, as well as provider satisfaction, within various system models. At this point there is insufficient empirical information to set an optimal or even a satisfactory caseload standard, although comparing averages and typical loads across states is valuable. We should continue to track and compare information and evaluations across states.

Reference

Jackson, B., Bataillon, K., Bell, J., Dinsmore, J., Finkler, D., Robinson, C., & Kinsey, J. (n.d.). *Case coordination: The Project Continuity model.* (Available from the Department of Special Education, Meyer Rehabilitation Institute, University Hospital, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-5450)

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